VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

July 19, 2011

Christopher Keough, Administrator
St Joseph's Residential Care Home
243 North Prospect Street
Burlington, VT 05401

Provider #: 0155

Dear Mr. Keough:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **June 20, 2011**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure

PRINTED: 06/28/2011
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0155	A. BUILDING _____ B. WING _____	C 06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S RESIDENTIAL CARE HOME	243 NORTH PROSPECT STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was completed by staff from the Vermont Division of Licensing & Protection on 6/20/11. The following regulatory violations were found.	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, facility staff failed to assure that medications for 1 applicable resident in the sample were consistent with all physician orders. (Resident #2) Findings include: Per record review on 6/20/11, Resident #2 had 2 sets of signed physician Standing Orders (S.O.) for administration of PRN Tylenol with different doses specified on each set of orders. One set of S.O. signed 8/19/09 (and never discontinued) ordered Tylenol 650 mg (milligrams) PO (by mouth) Q (every) 6 hours PRN (as needed) for pain and the other set of S.O., signed on 7/28/10, stated Tylenol 1000 mg PO Q 6 hours PRN pain. The back of the Medication Administration Record (MAR) for June 2011 included 9 days when staff documented administration of Tylenol 650 mg PO for pain. During interviews with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) between 2:30 PM and 4 PM on 6/20/11,	R128	St. Joseph Residential Care Home will assure that each resident's medication, treatment, and dietary services will be consistent with the physician's orders. 7/8/11 The standing orders for resident #2 were corrected for 650 mg per the physician's orders. 6/21/11 St. Joseph Residential Care Home will conduct quarterly in-service training for all med-techs regarding administering medications. The first training occured 6/25/11. 6/25/11 The Director of Nursing will review standing orders on a monthly basis. 7/1/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Administrator July 13, 2011

R128 POC Accepted 7/14/11
M. Bolton RN/Director RN

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R128	Continued From page 1 each confirmed that there should be only 1 set of current physician S.O. in the medical record and that staff failed to notify the MD to clarify the desired PRN Tylenol dose to administer. Refer also to R160.	R128		
R160 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a	R160		

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R160	Continued From page 2 person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, nursing staff administering medications for 1 applicable resident in the sample failed to adhere to the facility's policy/procedure for implementing and transcribing Standing Orders. (Resident #2) Findings include: Per observation on 6/20/11 at 12:35 PM and confirmed during nurse interview at 2:30 PM, the Med Tech staff member administered a requested dose of Tylenol for pain to Resident #2 without entering the physician's Standing Order (S.O.) for Tylenol on the front page of the MAR (medication administration record), as directed by policy. The facility's Standing Orders Policy/Procedure stated: "When S.O. are used, enter the order on the MAR". The Med Tech wrote the dose of Tylenol administered on the back page of the MAR only, not on the front page as directed by the policy. There were 9 PRN doses of Tylenol documented on the back of the MAR since 6/1/11. During interview after the observation (2:30 PM), the Assistant Director of Nurses (ADON) verified the policy should be followed and that staff are expected to write the physician S.O. for PRN medications on the front of the MAR and to document administration on both sides of the MAR. Refer also to R128.	R160	St. Joseph Residential Care Home will conduct quarterly in-service training for all med-techs regarding the facility's policy/procedure for implementing and transcribing standing orders. The first session was completed 6/25/11 The Director of Nursing will monitor and review MAR's on a monthly basis. R160 POC Accepted 7/14/11 M. Bolton RN/DNC to RN	6/25/11 7/1/11
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES	R206		

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R206	Continued From page 3 5.18 . Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report an allegation of resident abuse within 48 hours of learning of the alleged abuse for 1 applicable resident in the targeted sample. (Resident #1) Findings include: Per review, 2 facility mandatory self-reports of alleged resident abuse (neglect) were not reported to Adult Protective Services (APS) within the mandated 48 hour time frame. One report stated a Licensed Practical Nurse (LPN) failed to take action to protect a resident after he/she discovered they had made a significant medication error and the resident exhibited new symptoms. The facility learned of the incident on 7/23/10 and did not report the event until 7/29/10. A related self-report regarding the failure of another LPN to act after learning of the same allegation on 7/10/10, and who documented false information regarding the same resident, was also late. The facility learned of this allegation on 7/23/10 and did not report it until 8/2/10. The late reports were confirmed during interviews with the Administrator at 9:30 AM and the DON at 4 PM on 6/20/11.	R206	St. Joseph Residential Care Home will assure that all suspicions of abuse, neglect or exploitation will be reported to the Adult Protective Services within 48 hours of learning of the suspected, reported or alleged incident. Per our records, the initial incident pertaining to the 1st LPN was discovered on 7/23/10, and the initial report was made on 7/26/10 (see attached). Regarding the second reporting incident pertaining to the same incident but involving the 2nd LPN, notice was sent to the state on 7/30/10 followed by a followup notice on 8/2/10 (see attached). The administrator will ensure that all suspected cases of abuse, neglect or exploitation will be reported within 48 hours of discovery R206 PoC Accepted 7/14/11 M. Bolton RN/ RN Coord RN	7/8/11 7/1/11